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ABSTRACT

Despite all the recent attention being focused on the mental health of children, there remains a scarcity of effective programs for troubled youngsters and their families. One major reason for this failure to provide appropriate resources may be found in the inappropriate delivery systems developed for this task. An innovative family advocacy model for the delivery of mental health services to troubled children and families is described. Excerpts from case studies are utilized to point out significant aspects of the model and to demonstrate the effectiveness of the family advocacy approach. Critical elements of the family advocate's role are specified. Conclusions point to the need for comprehensive and coordinated ecological approaches to the delivery of mental health services. (Author)

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Family Advocacy in the BRIDGE Program:*

A new model for the delivery of mental health services for children

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Ecological Approaches to Service Delivery: New Roles for Community Psychologists (Joseph T. Himmelsback, Chair)

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Family Advocacy in the BRIDGE Program:
A New Model for the Delivery of
*Mental Health Services for Children**

The mental health of children is a frequently discussed and continually studied issue. Estimates of the incidence of emotional disturbence in children vary greatly depending on definition, location, means of assessment, etc. One of the most thorough studies (Glidewell & Swallow, 1968), prepared for the Joint Commission on Mental Health of Children found; 30% of elementary school aged children have at least mild adjustment problems, 10% need clinical assistance, and 4% would be referred to clinical facilities if they were available. If we add the recent finding (Children's Defense Fund, 1974) that nearly two million children between the ages of 7 and 17 have been excluded from school in America, many because of emotional "handicaps," then it seems easy to understand why programs for children should be a high priority on any list of mental health needs.

Despite all the recognition given to the issue, the needs of children with regard to mental health are still not being met. Most recent estimates (Behavior Today, 1976) indicate that seven million children need professional assistance for mental health problems and that, alarmingly, about 90% of these youngsters will not get the help they need. One of the major reasons for this failure may be seen in the means by which service to children is typically delivered. For example, although the mental health needs of children (and of adults for that matter) are broadly defined, services are often too narrow to have much of an impact. Even when effective service is provided today, there is often no mechanism for delivering appropriate treatment when problems occur tomorrow. Although it is almost universally agreed that early intervention has a better chance

of succeeding, children are often unable to receive treatment until their situation is so severely deteriorated that failure is the likely result.

What is needed then is a more comprehensive, readily available, broadly defined service delivery system; an ecological approach to service delivery that has the built-in ability to do effective followups, can utilize the range of existing community services, and can take on the often neglected responsibility of coordinating services being provided to any one client. Most importantly, such a service must have the prevention of emotional problems as its primary concern, in order to break the cycle of creating still another inadequate treatment program for a range and depth of emotional disturbances that can never be "cured" by the traditional direct service model. If the mental health problems of children are ever to be addressed effectively, it must be through the provision of positive mental health models for families and the corresponding prevention of severe emotional difficulties.

BRIDGE Program

The BRIDGE Program began in 1970 as a comprehensive year round, psychoeducational program for troubled children. Working with youngsters between 7 and 12 years of age whose problems were severe enough to cause them to be marginal participants in the school experience or might even result in their exclusion from school participation, the BRIDGE Program set out to help children become successful, effective participants in regular school programs. More specifically, program goals were to help children improve their abilities to function personally, socially, and academically in their own homes, communities and schools; to help "marginal" children become effective, capable participants in normal environments, and ultimately to BRIDGE (hence the name of the program) the gaps that were disrupting their lives.

Since its inception, the underlying philosophy of the BRIDGE Program has been firmly based on an ecological or systems viewpoint. Such a posture assumes:

> *Every child is an inseparable part of a small social system--an ecological unit consisting of home, school, community, social agency, church, etc.*
>
> *Each element of a given system has an impact on the child and, through the child, on each other (i.e., youngster's difficulty at home can have serious repercussions on his behavior at school, etc.)*
>
> *Improvement in any element of a given system also has an impact on the child and ultimately on the entire system.*
>
> *The goal of mental health interventions is to balance the system--to make t work for the child and for the others who inhabit his/her environment, even after the intervention is completed.*

In an effort to operationalize this philosophy, the BRIDGE Program was developed to be as totally comprehensive as possible, working on a year-round basis with all of the individuals and institutions that touch and affect a child's life. Since many programs had failed because of an inability to be flexible enough to respond to the needs of the people they were designed to serve, the BRIDGE Program; would be consciously oriented toward the specific needs of each individual, would be spontaneous enough to respond when people asked for assistance, and would never become rigidified to the extent that it would be unwilling to help with the everyday problems of living so many programs choose to ignore. With all of that in mind, the BRIDGE Program was initially developed then to have the following facets:

The <u>Children's Program</u> has two parts. First, there is a psychoeducational summer camp which all of the children attend. At the 3-4 week overnight camp, children are provided a full range of summer camping experiences - swimming, boating, sports and games, small group living and good food, and a relaxed

atmosphere. In addition, children have individual attention from members of a large well trained and supervised staff, many of whom continue to work with the children during the academic year.

The second part of the Children's Program involves a variety of educational and recreational activities engaged in by each child and his/her counselor during the year. Often the special relationships developed between campers and counselors during the summer can continue during the year as each child/counselor pair spend time together each week engaged in a variety of activities that seem appropriate in terms of the child's personal and social growth and the overriding goals of the program. Additionally, during the year there are a number of small group activities, "all-program" activities, and opportunities for the children to pursue particular interests with their counselors and other BRIDGE Program staff.

The Family Program was originally designed to provide individual and group counseling for parents of troubled children but was quickly broadened to include recreational and social activities as well. Thus, in addition to providing individual and family counseling when appropriate and serving as crisis interveners when called upon to do so, the BRIDGE Program has also sponsored bowling parties, bingo games and coffee hours.

Originally, the BRIDGE Program maintained a separate staff to work with families, although at times the child's counselor has been a crucial factor in the development of a relationship between a particular parent and the program. Shortly after the program started, the benefits of adopting the same kind of therapeutic relationship approach to families that had been utilized with the children became clear.

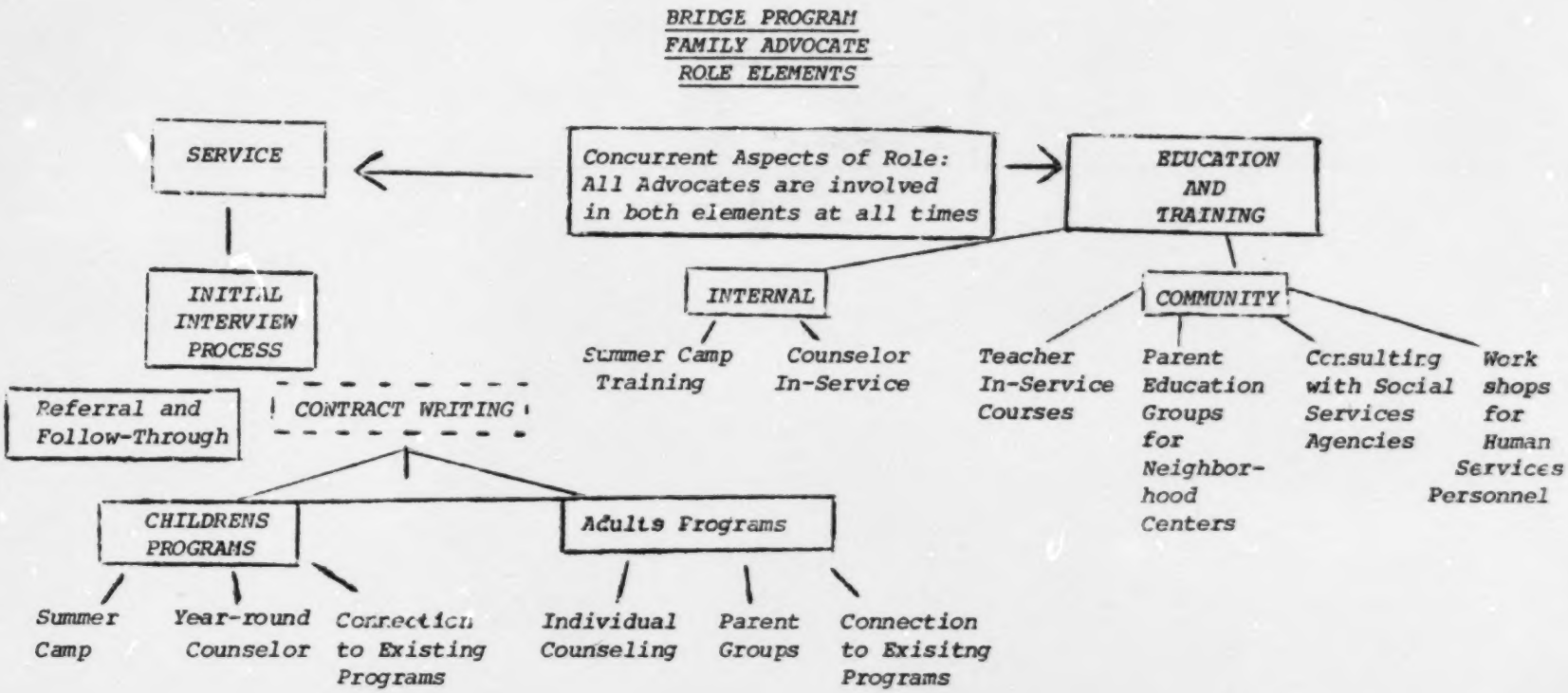
In the School Program, a BRIDGE Program staff member maintains continued

contact with a designated liaison person in every school the children attend. In this way, it has often been possible to avoid trouble before it began, intervene more effectively in case of a crisis, and work cooperatively for the benefit of a particular child. This has also been an effective way to begin developing a relationship that ultimately helped the program have more of an impact on a particular school. As the BRIDGE Program became increasingly interested in developing a preventive model (while continuing to provide direct service), the school program has become a crucial area.

The Children's Program--Family Program--School Program model described above did function, with periodic refinements, as a successful basis of program operations for almost five years. By the spring of 1975 however, it became clear that the BRIDGE Program was encountering some major difficulties in providing the kinds of services that were desired and a two day staff retreat was held in an attempt to redesign the total program model. Specific concerns included the ever growing need to expand BRIDGE Program services, an equally pressing need to better coordinate internal program elements, and significant dissatisfaction with the BRIDGE Program's inability to transcend the direct service model in order to develop a more preventive orientation that would ultimately impact on more children.

Family Advocacy

The result of that staff retreat was the creation of a new model for BRIDGE Program service delivery; Family Advocacy. As we prepared for the upcoming year, the BRIDGE Program was restructured so that many of the responsibilities previously held by staff members of the School and Family programs were subsumed under the single new role of Family Advocate. As conceptualized in the BRIDGE Program, the Family Advocate role includes both a Service Dimension and an Education and Treaining Dimension. The following figure portrays the varied functions of the Family Advocate Role in the BRIDGE Program.


BRIDGE PROGRAM
FAMILY ADVOCATE
ROLE ELEMENTS
SERVICE
Concurrent Aspects of Role:
All Advocates are involved
in both elements at all times
EDUCATION
AND
TRAINING
INITIAL
INTERVIEW
PROCESS
INTERNAL
COMMUNITY
Summer Camp
Training
Counselor
In-Service
Teacher
In-Service
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Parent
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with Social
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Work
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for
Human
Services
Personnel
Referral and
Follow-Through
CONTRACT WRITING
CHILDRENS
PROGRAMS
Adults Programs
Summer
Camp
Year-round
Counselor
Connection
to Existing
Programs
Individual
Counseling
Parent
Groups
Connection
to Exisitng
Programs

Direct Service

The first responsibility for a Family Advocate is the implementation of a comprehensive initial interview process. When a child is referred to the BRIDGE Program, the Family Advocate must: read the written referral and discuss it with the person who submitted it, set up an appointment to talk with the child and at least one parent in the family's home, talk on the phone or meet with all other school or agency personnel who are involved with the family, and formulate an assessment of the family's needs at the current time.

When this has been completed, the Advocate attempts to match the family's needs to the resources available through programs in the community, including the BRIDGE Program. Basically, there are three outcomes to each initial interview process:

1. Referral and Follow-Through to Existing Community Services

When the needed service is being offered in the local community, family advocates will inform families, assist them in gaining access to the service, and follow-up to be certain the service is actually provided.

2. Children's Services

For many families, the clear and immediate need will continue to be service for a specific child. In such cases, family advocates will be able to offer the summer camp and year-round program experience, other forms of child counseling (not necessarily including camp), etc. A new kind of service through which a BRIDGE Program staff member serves as a gatherer of facts and mediator in child-school-family disputes has also been included in this category.

3. Adult Services

When the adult member of the family seems to have the greatest needs, family advocates will try to provide the needed service. Direct service might take the

form of individual counseling or parent education groups. Frequently too, family advocates provide the support and assistance that can enable adults to more accurately define their problems and more effectively resolve them.

Education and Training

This is the more system-focused preventive aspect of the Family Advocate role. There are two major elements:

1. Internal Training and Supervision

Family Advocates have a major role in the development and implementation of a four-day staff training program that occurs at the beginning of the BRIDGE Program summer camp each year. Following that, Family Advocates supervise the work of counselors at camp and continually throughout the year. In addition, Family Advocates take a responsibility for any other BRIDGE Program training needs that occur at any time during the year. (i.e., A two-day workshop for counselors who begin their work with the BRIDGE Program in September and don't have the Summer camp experience or training.)

2. Community Education

This is a broad category that has included a variety of activities, most of which have been aimed at the adults whose work with youngsters makes them such potentially important figures in the lives of all children. Family Advocates have conducted inservice courses for local teachers and administrators, consulted with social service agencies about mental health program development, developed a format for parent education groups and provided the leadership for such groups to community agencies, conducted workshops for human service personnel, and participated in local comprehensive mental health planning efforts.

Case Histories

The following examples have been extracted from the formal evaluation report completed at the end of the 1976-77 BRIDGE Program year. Three cases have

been selected and portions are quoted below in an effort to more clearly explicate the actual functions performed by Family Advocates.

The Case of MR

MR is an eight-year-old boy who came into the BRIDGE Program because of the school social worker's recommendation. MR was engaging in what the school termed as "wild" behavior--spitting, running around, shouting, swearing and other acting out behaviors. MR attended camp which concentrated on the above behaviors and some slight progress was achieved, but MR has considerable distance to go.

MR's counselor sees him weekly, mostly on Saturdays. She takes him to her sorority house, and does crafts with him and allows him to mix with the others there.. Her goals for MR are to have him be more expressive verbally, and more at ease socially.

MR's mother said that he was in a special school when he was selected for BRIDGE. BRIDGE was going to teach him to get along with others, but she hasn't seen that much of a change in him. BRIDGE is important because it helps him to go places; otherwise, he would be confined to the area around home because they have no car. When he comes back from his visits with his counselor he is a changed child. Once the mother called the counselor when she could not tolerate his behavior any more and needed some relief--the counselor came. MR has had a psychiatrist, gone to child guidance, but nothing seems to help.

The advocate comes over frequently (the mother could not remember the name of any other adult whom she mentioned with the exception of the advocate--the expression on her face made it clear that the advocate is an extremely significant person in her life). They talk about children, legal crises she is going through, vocational plans. She calls the advocate a lot, and the advocate gives

her advice. She trusts the advocate, she says, because the advocate really cares about her and is not there to pry. The mother has been cited for child neglect, which has brought her into contact with Children's Division. The advocate helped her with her contact there; she feels that the advocate does a great deal more with her and for her than her caseworker.

There have been times when she has wanted MR placed in an institution. The advocate, however, fights that, and it is only with the support of the advocate that the mother feels that she can continue to keep MR at home. She feels that BRIDGE is a good program, and something that was needed a long time ago--if there were no BRIDGE she feels that she would "probably go nuts." If BRIDGE had been there before, maybe, she feels MR wouldn't be the problem that he is.

BRIDGE'S working with MR provides support for him that other agencies have been unable to provide. According to the school social worker, MR is currently functioning satisfactorily in the school. He is enrolled in a regular class, and teachers no longer have reason to send him out of the class for disruptive behavior. "He was running all over the school when he first came."

The Case of UB

The BRIDGE Program came into UB's life because of contacts through the Catholic Youth Organization. UB at the time was a shy, withdrawn child whose father had recently died and whose mother was and continues to be bed ridden. UB went to summer camp where the focus was on her becoming more outgoing and providing her with support to draw her into more social interactions.

UB's counselor sees her once a week, on Saturday afternoons. He calls the home first. He talks to her mother, keeping her informed about what he is doing with UB. He feels that he doesn't know anything about her mother, but he does know that she likes the contacts which being in BRIDGE provides for UB.

Nevertheless, he sees a shared goal to phase UB out of the program. He, the advocate, and UB's mother have met together to discuss UB and the program. She and the advocate keep in regular, frequent touch, talking over the relationship between him and UB.

UB has changed a great deal since, and because of, BRIDGE, according to her mother. She is much more responsive, out-going, responsible, self-sufficient, and efficient. Although she now has friends, she still does fantasize a great deal, carrying on conversations with imaginary companions.

UB's counselor last year was very well liked and attentive. Her weekly visits were a treat. And even though there is another counselor this year, last year's counselor still keeps up contact, so that UB has a number of concerned adults in her life, all of whom are viewed by UB as close friends.

The advocate makes weekly visits. The mother sees her as a source of support to the family. Because the advocate was aware that UB and her brother were very close, she provided a counselor for him too.

UB's mother says that she is saddened by the end of the BRIDGE Program, and thinks that if the parents had been more supportive--giving instead of just taking--the program might continue. She finds it a "wonderful program," with the contact through the year even more crucial than camp, and with the relief that the children get from their homes and their parents an extremely valuable element.

At school UB needs some help academically and both the teacher and the school social worker are aware of UB's home situation. The advocate maintains regular contact with the school and is currently trying to arrange a meeting with the teacher and social worker and UB's mother at home.

The Case of NM

NM, a seven-year-old girl, was referred to BRIDGE by her teacher. NM is a member of a special education class. She is a suspected child abuse case because of bruises and scratches. The reporting of these by the school for action against the family resulted in anger and alienation toward the school by the family.

According to her mother, NM was selected because she was a big problem; she is in a special school for children who are too distracting to be in regular schools. BRIDGE told her that with NM they would work on sharing, playing, following rules. When she came back from camp she was very polite, but then she changed. She had a counselor for a short time, whom she seemed to like but conflict in hours prevented the relationship from continuing. She said that the counselor had tried to see NM during school hours, but that the teacher didn't like it. She thought that the counselor's goal for NM was to have her be more expressive of her feelings in acceptable ways.

The advocate comes over every Wednesday morning. Right now they are talking about child abuse, for which the mother has been cited twice. The advocate is in the process of setting up therapy through pastoral counseling. She looks forward to the advocate's visits, finding them very helpful. There is no one else whom she can talk to about her problems. Her husband shares her feelings about the role and worth of the advocate in their life.

The advocate has helped her in dealing with other adults. The mother and the teacher used not to be able to communicate, especially since it was the teacher who turned the mother in for child abuse, and the mother felt that the teacher was always accusing her. The worker from Child Abuse also made her defensive, especially since they accused her of murdering her youngest child. The

advocate has also sat in on conferences with that worker, and has changed the attitude of that worker so that they can talk. For the first time, in a few weeks, the mother is going to try to have a school conference without the advocate there.

The mother feels that BRIDGE could teach NM respect, politeness, getting along with other children. Also it gives the parents a break from a problem child. The advocate has been helpful in seeing NM and her motives, and extremely crucial to her; without that contact, she feels, she would be let-down and have nowhere to turn.

There is no counselor at present, but the counselor reported that the family on more than one occasion set up an appointment but were all absent from the home at the specified time. It was decided then to work mainly through the advocate, and the fact that both parents regard the advocate as their friend is a significant breakthrough. Letting NM attend camp was a major concession by the family. The camp experience was most effective in getting NM to intrude less on other children, reduce fighting, and be less impulsive, but it was not a steady progression over the three weeks of camp. While NM's problems are far from alleviated, the significant others in her life: parent's, teacher, other school personnel are co-operating more than at any other time.

Implications of a Family Advocacy Approach

In all the cases above, whether direct service, education and training, or some combination, the Family Advocate is the key staff person. It is the advocate who has the ultimate responsibility for defining the problem, constructing the contract, convening resources, maintaining contact with the family, and supervising any direct service staff who work with adult or child members of the family. And yet, the Family Advocate Model is a very efficient system of

service delivery.

During the 1975-76 BRIDGE Program year, six Family Advocates, each of whom worked between 10 and 20 hours per week, formed the central core of the BRIDGE Program. Over the course of that year, these six people provided a variety of direct services to between 40 and 50 families at any given time, supervised up to 30 children's counselors, taught six separate parent education courses throughout the community, and attended a variety of meetings with school and social service agency personnel.

The BRIDGE Program has n w completed its second year of operations utilizing the Family Advocacy model. While small refinements have been made, the model has stood the test of two very demanding years and, according to the formal evaluations conducted in each of the past two years, enabled the BRIDGE Program to attain its goals and become a fully functioning model program. While it is not appropriate to construct rigid boundaries around the role of Family Advocate, the following elements seem to stand out as critical to the success of this new model.

1. Family advocates are always involved in both the Service and the Education and Training aspects of the Program at any given time.
2. Family Advocates share in the administrative and decision-making responsibilities of the total program.
3. Family Advocates supervise all other BRIDGE Program staff who work with, for, or on behalf of any member(s) of an advocate's family.
4. In all of their activities, one central tenet of a Family Advocate's role is to <u>always</u> focus on <u>coordinat</u>on of services.
5. Family Advocates try to teach problem-solving skills by working with families on a continuing basis in an effort to help family members identify the

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5. Family Advocates try to teach problem-solving skills by working with families on a continuing basis in an effort to help family members identify the

source of difficulties, develop plans that have the possibility of succeeding, implement the r plans, evaluate their progress, and make new plans if necessary.

6. Family Advocates can serve as the links that bind the varied agencies that participate in children's mental health programming into a strong and effective chain.

Conclusions: Toward a Model of Family Advocacy.

The shift to a Family Advocacy model has had a very clear and positive effect on the scope and the effectiveness of the BRIDGE Program. The 1975-76 Evaluation Report stated:

> "We want to stress in clear, unequivocal terms that from all of the evidence that we were able to collect, the BRIDGE Program. . .is functioning more successfully than it has at any previous time in its history. Its work with the individual child, the family, public schools, and other agencies has been such that the BRIDGE Program has come of age as an important instrument in dealing with the very difficult problems it seeks to ameliorate."

One year later, the 1976-77 Report noted:

> "A year ago the Family Advocate model was beginning to function in a meaningful and relevant way. The greatest change in the BRIDGE Program over the past year has been the maturing of the role of Family Advocate. . . .
>
> "In our interviews with the advocates this year, they were all able to articulate much more clearly how they worked with their

families how they saw the role of advocate, the limitations of their role, and some of the difficulties or shortcomings in their position.

. . . . .

"The Family Advocate provides the families with someone the family can trust. In short, someone who will not confront the family with institutional or legal consequences. In our family interviews this concept was reiterated. For several of the families, the advocate represents the one person to whom they feel free to call on. The Family Advocate role has been a crucial development in the BRIDGE Program, and as far as the families themselves are concerned, it has been a vital one."

The recent report, (Challenges for Children's Mental Health Services, April, 1977), prepared by the MITRE Corporation in collaboration with the Mental Health Service Development Branch of the National Institute of Mental Health provides some insight into the affectiveness of ecological approaches to service delivery (the Family Advocacy model being one example of such an approach). That report, which represents the surveyed opinions of a diverse group of fifty experts in the area of children's mental health, identifies some specific mental health needs of children, services that must be developed or improved in order to meet those needs, and barriers that currently impede the delivery of those services.

It is striking to note that of the ten services selected as most important in that survey, the BRIDGE Program Family Advocacy model has been directly providing eight. That is to say, Family Advocates have been involved in; training and counseling parents to foster healthy mental development in children, providing early detection and referral for appropriate intervention, educating

all children in life management skills, training educators through a developmental and humanistic approach, strengthening and supporting families, improving service coordination and accessibility, providing community-based out-patient treatment, and training teachers about the needs of handicapped children. Also, while Family Advocates have typically not been directly involved in the provision of the remaining two needed services (comprehensive health care and community-based residential treatment in non-hospital settings), they certainly have acted as facilitators for the provision of those services.

It's also important to realize the impact that an ecological service delivery approach could have on the ten barriers which survey participants identified as presenting the biggest impediments to the development and/or implementation of needed services. In each case a conprehensive, coordinated systems-oriented approach might be expected to carry more than the usual clout to bear against the following major obstacles.

1) Services not tailored to needs of individuals
2) Poor working relationships among service providers and agencies
3) Decision-makers do not perceive the need for services
4) Inappropriate input to planning for services
5) Prohibitive cost of mental health services
6) Political/Social resistance to change
7) Lack of ability to reach potential clients
8) Medical model impedes the provision of preventive services
9) Lack of definition of mental health
10) Services dehumanize and frustrate clients

Community Psychologists, attempting to develop effective and efficient models for the delivery of psychological services would do well to consider a Family Advocacy model. A recent front-page report in the APA Monitor (July, 1977) discusses NIMH efforts to develop new support systems in order to construct missing rungs in the mental health services ladder. That article states:

> *"According to NIMH, communities need one agency -. . .- that will glue disperate services into a comprehensive community support system and make sure that the clients move through the network in an orderly fashion." (p. 4)*

An ecological approach to service delivery can become just such a comprehensive community support system, as has been shown in the BRIDGE Program, and the development and implementation of such systems are becoming increasingly important aspects of the role of community psychologist.

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